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New Britain. CT 06053
Phone: 860-612-6305
FAX: 860-612-6304

The Parkinson's Disease and Movement Disorder Center

Program Referral Form

REFERRING PRACTICE/PHYSICIAN

NAME: ______________________________________ **PHONE:**____________________________
ADDRESS:____________________________________ **FAX:**______________________________
PCP:____ **PHONE:**_____________________________
MD Signature: ____ **Date:**____________________

PATIENT INFORMATION

NAME:____________________________________ **DOB:**_________________ **GENDER:** ☐ **M** ☐ **F**
ADDRESS:____
PRIMARY TELEPHONE:_____________________ **EMAIL ADDRESS:**_________________________________
LANGUAGE:_______________________________________ **INTERPRETATION NEEDED?** ☐ **Y** ☐ **N**
ETHNICITY: ☐ Hispanic ☐ Non-Hispanic
RACE: ☐ American Indian ☐ Asian/Pacific Islander ☐ African American ☐ Caucasian ☐ Other: ___________
CONSERVED: ☐ **YES** ☐ **NO** **CONSERVATOR NAME:**____________________ **PHONE:**______________________

EMERGENCY CONTACT ☐ / CONTACT FOR SCHEDULING ☐ (*Please check one)*

NAME:__________________________________ **PHONE:**____________________ **RELATIONSHIP:**_________

INSURANCE INFORMATION *****Insurance REQUIRES clinical documentation that supports the need for an exam)***

PRIMARY INSURANCE:____ **MEMBER ID#:**_____________
SECONDARY INSURANCE:____ **MEMBER ID#:**_____________

Primary Clinical Question / Referral Question (required)

____
____

DEGREE OF URGENCY ☐ **Routine** ☐ **Urgent (Recent Hospitalization/ED Visit)** ☐ **Priority (recent exacerbation)**

Pertinent Clinical Data:

Diagnosed with Parkinson's Disease / Movement disorder? ☐ Yes ☐ No
If yes – Is patient aware of the Dx? ☐ Yes ☐ No

Date of last Exam: ________________
Primary Dx.:____
Secondary Dx.:____

Check all that apply: (Please include any relevant reports or discs of studies if available).

☐ Medications ____
____

☐ Deep Brain Stimulation ☐ DaT Scan ☐ MRI ☐ Other labs or relevant studies ________________
____